

Approaches to Delivery of Family Planning Services

A young married couple with an infant child decided they would like to wait a few years before having their second child. When the wife went to the well-baby clinic on Friday, she asked how she could delay her next pregnancy. The nurse told her to return on a Tuesday, which was the day the clinic provided family planning services. The young woman knew she would not have time to make a separate trip for family planning services as well as baby care, so once back in the village she asked a friend who used family planning where she went for services. The friend promised to ask her community health and family planning worker to visit the woman. At the visit a few days later, the community worker explained the methods of family planning available. They decided that the injectable hormonal contraceptive was the best method for the young woman at this time. The community worker administered the shot, collected the small fee, and said she would return during her next visit to the village. Then, if the woman had no problems with the method, the community worker would return every three months to provide the injections.

For a family planning program to meet the needs of its clients and achieve program goals, its services must be *accessible* to everyone who

wants to use them. The easier it is to obtain contraceptives and services, the more likely it is that people will use them.¹ Accessible services meet the following criteria:

- They are relatively *easy to get to*.
- The clinic provides *good quality care*: clients do not wait too long for services, providers listen and respond to the needs of the clients, providers are technically skilled, and clients receive the services they need.
- Services are *affordable*.
- The concept of family planning and the services provided by the program are *well publicized* so that everyone who wants to space, limit, or prevent births knows that there are ways to do these things, knows about the program, and knows where to get services.
- Staff *fully and clearly explain the contraceptive methods* that are available so that clients can decide what method is best for them.
- *An adequate supply* of contraceptives is always available.
- Services are provided at *regular, known times*.

How do the family planning services offered by the health system in which you work respond to your clients' needs? How many of the characteristics listed above describe your program? Can you provide each client with the right contraceptive method and medical care if there are complications? The range of health and family planning services offered in Africa differs considerably from country to country. Some countries offer family planning services through a well-developed network of clinic services. Others have established clinic-based systems but find that shortages of medical personnel and money prevent them from reaching remote populations. As a result, these countries have developed community-based approaches to providing health and family planning services, including distributing some contraceptives through commercial sales. Family planning program managers can choose from a variety of service delivery approaches. In fact, managers can select a combination of approaches to make their services accessible to family planning clients in their area.

DELIVERY STRATEGIES

Service delivery strategies need to be tailored to reach populations in different locations—urban areas, rural towns, villages, and remote areas. The most common service delivery sites include clinics, community-based distribution (CBD) programs, commercial retail sales, workplace programs, postpartum programs, and private physicians. Advantages and disadvantages of some of these approaches are presented in Table 25:1.

CLINIC-BASED SERVICES

A clinic-based approach is reasonable in areas where clients do not live far from the clinic. Clinics often have the advantage over other service delivery strategies of being able to provide methods that are more medically complex, such as intrauterine devices (IUDs), hormonal implants, injectables, and sterilization.

In urban areas and rural towns, family planning is most often provided by clinics that integrate it with other health services for women and children or offer it only on certain days of the week. (It is preferable, but not always possible, to have family planning services available during all the hours that the clinic is open.) Most government-run clinics are integrated clinics that offer multiple health care services; privately funded clinics generally offer only family planning services.

An *ideal* integrated clinic has these features:

- All staff members are trained to provide family planning services.
- All staff are trained together and thus feel confident of each other's abilities; one member can readily stand in for another.
- One supervisor oversees all staff members.
- The supply of medicines, contraceptive supplies, and vaccines through one channel is dependable.
- Difficult cases are referred to specialists and the original providers follow through on the results.

Table 25:1 Advantages and disadvantages of approaches to providing family planning services

Advantages	Disadvantages
Clinic-based Services: General	
<ul style="list-style-type: none"> • Clients are seen at each visit by health care professionals. • Problems can be detected and treated during the visit. • A switch in contraceptive method can be accomplished easily at the clinic. • The whole range of contraceptive services can be provided, including sterilization, intrauterine devices (IUDs), and injectables. 	<ul style="list-style-type: none"> • Clients are limited primarily to those living near the clinic. • The nurse or midwife might not be familiar to the client because the client may not see the same staff member each time. • Clients are expected to come on their own initiative, both initially and for follow-up. • Clients may have a long wait before receiving services.
Clinic-based Services: Integrated family planning and maternal and child health	
<ul style="list-style-type: none"> • Clinic can attract mothers coming for other services and introduce them to family planning. • Users can receive pediatric, obstetric, and gynecologic care, along with family planning services in one setting. • In theory, there are easier transitions from postpartum to family planning and from family planning to prenatal care. • Clients who are uncomfortable with the social stigma, if there is one, of contraception are not so easily identified as users of family planning. • Family planning can be established as an important element in the health of women and children. • Start-up costs of providing family planning care are low if maternal and child health (MCH) services are already available. 	<ul style="list-style-type: none"> • Family planning issues are generally considered only after child and maternal health problems are addressed. • Administrative functions are more complicated, especially if contraceptive resupply and reporting of service statistics for family planning services are not integrated with the support systems of the MCH program. • Workers who are not specifically trained in family planning may lack the needed skills and motivation to be effective providers. • The physical facility (clinic or health center) may not be able to accommodate family planning services.

Table 25:1 Advantages and disadvantages of approaches to providing family planning services (Continued)

Advantages	Disadvantages
Clinic-based Services: Family planning only	
<ul style="list-style-type: none"> • Family planning workers are more motivated to deliver family planning. • More time can be spent counseling and educating each client about family planning. • Generally, a better worker-to-client ratio exists for family planning. • Workers who have received special training in family planning may be more effective. • Unmarried women without children may be more comfortable in this type of facility. 	<ul style="list-style-type: none"> • Clients must be motivated to come on their own for family planning services. • Transitions are not smooth from the postpartum to the time a woman needs family planning services or to the time she needs prenatal care. • Women must visit other facilities to receive other health services. • Clinics cannot offer services that attract many mothers who then learn about family planning while at the clinic. • Clients, particularly unmarried ones, who are uncomfortable with the social stigma of using contraception may not want to be seen at the clinic.
Community-based Distribution (CBD)	
<ul style="list-style-type: none"> • This option is more convenient for clients, who need not travel long distances. • Supplies are distributed by someone the client knows and trusts. • Postpartum mothers can be identified and visited. • Follow-up is easier. • Client motivation is maintained at a high level through continuous interaction with the CBD worker. • CBD is sometimes a cost-effective approach. 	<ul style="list-style-type: none"> • Full MCH or family planning services are not offered. • Immediate access to clinical staff for managing problems is not available. • Some health professionals resist having the CBD workers or volunteers offering services. • The client may feel there is little confidentiality. • The client may lack confidence in the nonmedical worker. • Initial program costs per client may be high.

Table 25:1 Advantages and disadvantages of approaches to providing family planning services (Continued)

Advantages	Disadvantages
Commercial Retail Sales	
<ul style="list-style-type: none">• Can reach remote areas not reached by other programs.• Clients need not travel long distances.• Distributors are motivated because they earn profits from sales.• Availability of methods is well publicized.• Client does not have to wait in a clinic to receive the method.• Client has anonymity.• Costs to the client and the government can be low.• Resupply to distribution points is usually reliable.	<ul style="list-style-type: none">• Full services are not offered.• Clients must go to a clinic for management of their health problems.• Starting a program can be costly.• Promotion and advertising of contraceptives may be subject to criticism.• Full client education and counseling on contraceptive methods may be lacking.

Unfortunately, many countries do not have enough health workers to staff their clinics. However, with some supervision by a physician working part time, trained nurses and midwives can examine women, prescribe the appropriate family planning methods, and manage minor problems.

COMMUNITY-BASED DISTRIBUTION (CBD)

In areas that do not have clinics nearby, family planning services may be made available through CBD programs. In this approach, CBD workers, usually village women, are trained to educate their neighbors about family planning and to distribute certain contraceptives. In some programs, CBD workers also provide some primary health care services.

In their training, the CBD workers learn the basic concepts of family planning, how each method must be used, what the precautions and side effects are for each method, and how to keep simple records and report the information to their supervisor. CBD programs usually distribute condoms; some also provide pills and spermicides, and a few have trained CBD workers to administer injectables. In some programs, the workers receive some kind of payment; in others they are strictly volunteers. A midwife, family planning nurse, program coordinator, or other staff member is usually responsible for supervising the CBD workers' activities and managing any problems that occur.

Family planning administrators may find that CBD services are most effective when a program is fairly new and people are not familiar with contraceptives. Because local residents bring family planning services directly to individuals, they make family planning both convenient and culturally sensitive, and these residents are always nearby to answer questions. Adding CBD services to existing clinic services has been shown to make family planning more acceptable to a community and to increase a program's impact.¹

COMMERCIAL RETAIL SALES

In both urban and rural areas, if people are willing to obtain contraceptives from sources outside the health care system, commercial retail sales (sometimes called social marketing) can make some contraceptive methods very accessible. In this approach, contraceptives such as oral contraceptive pills, condoms, and spermicides are sold at reduced, subsidized prices in pharmacies, market stalls, stores, barber shops, beauty salons, and bars and are advertised on the radio and in newspapers. Some programs also offer injectables and IUDs, which clients purchase in pharmacies and take to a private physician or a clinic for insertion.¹

When a commercial retail sales approach is used, the retailers are often the customers' only source of information about the products. These retailers should be given training in basic information about the products and how to refer people who have problems with a contraceptive.²

OTHER APPROACHES

Several other service delivery methods have been used. Some companies provide family planning services during certain hours at the *workplace* to reduce health care costs and absenteeism related to pregnancy and childhood illnesses.³ Some hospitals and maternities provide family planning counseling and services immediately *postpartum* because that may be the only time that a woman comes in for health care and is available for family planning education. (This approach is discussed in detail in Chapter 12, Lactation and Postpartum Contraception.)

In most countries, family planning services are often available from *private physicians*, although generally at a higher cost. Other approaches involve training paramedics, pharmacists, traditional birth attendants, midwives, traditional healers, and outreach workers to provide family planning services.¹ Whatever delivery strategies they have chosen, African countries have, in recent years, dramatically increased access to family planning services.

FINANCING FAMILY PLANNING SERVICES

Family planning services are usually financed through one or more funding strategies:

- Government support
- Private providers, such as family planning associations
- Client charges (fee for service, registration fee, membership fees, or copayments)
- Grants from international or local donors
- Insurance or other third-party payment mechanisms, in which the client pays part of the fee and the rest is paid by the employer, health plan, or insurance company
- Cross-subsidies (revenue generated by and transferred from other health services)

Government support for family planning services is usually limited to services that can be provided by the government's existing facilities, staff, or projects.

Private agencies, such as family planning associations affiliated with the International Planned Parenthood Federation, sometimes charge enough to cover all costs, but more commonly charge only a fraction. Such agencies are often located only in larger cities.

Clients are often charged a flat fee, such as a registration fee, when they are first seen in a clinic or a fixed service fee at each visit. Less often, fees are charged for a particular service provided, such as IUD insertion or sterilization. Charges rendered often cover only part of the cost of providing the service. Client fees are discussed in greater detail below.

Many programs receive assistance directly or indirectly from international donor agencies. These grants often support specific elements of programs, such as equipment, contraceptive commodities, or informational materials.

In most of Africa, membership fee payments, copayments, insurance coverage, and other third-party coverage are virtually unknown as a source of revenue.

Cross-subsidization provides support for one service by charging extra for another service or by charging more in one location than in another. This strategy is most often used in an integrated setting where several services, including curative care, are provided. The revenues generated from curative care fees can subsidize some costs for other programs whose benefits are less obvious to clients (preventive services such as family planning and immunization). In locations where clients are able to pay more, higher fees may be charged to subsidize lower fees in poorer areas.⁵

FEE PAYMENT SYSTEMS

In some countries, clients are asked to pay a small fee for their contraceptives. However, there are several factors working against charging fees for services. Family planning and other health services operated by African governments have often been provided without charge to patients, for the following reasons:

- Throughout most of the first half of the 20th century, medical care was usually provided free of charge by colonial authorities and missionaries. This pattern has continued since independence.
- A commonly held belief is that family planning should be provided free as a matter of principle. This belief persists despite evidence that people will pay for goods and services if they are of good quality and indeed prefer them to those they can get for free, which they perceive to be of lower quality. In addition, governments with a limited health budget may not be able to afford to provide free services or contraceptives everywhere they are needed, or they can provide only inadequate services.
- Charging fees excludes the very poor from services. Poor clients may be forced through desperation to pay for acute curative care, but they are likely to strongly resist paying for preventive care, including family planning.
- Many international donors furnish vaccines, medicines, and contraceptive supplies under the condition that clients receive them free of charge. (This policy is gradually changing.)
- Collecting and transferring payments received from clients is time-consuming and perceived as an inappropriate task for nurses and other clinic staff who are trained to provide medical care. In addition, many clinics have difficulty maintaining accurate accounting or billing records. Sometimes the cost of managing the money is more than the amount collected.

Despite these barriers, completely subsidized services probably cannot continue much longer. Neither governments nor donors can afford to continue to provide free care. Although contraceptives are often supplied by donors with the requirement that they be provided

free to clients, it may still be possible for programs to charge clients a fee for the services provided by clinic staff. Some commercial retail sales programs have successfully marketed contraceptives for a small price, which shows that some clients are willing to pay for them. In fact, studies have shown that people often place a greater value on services and contraceptives they purchase with their own money and thus may be more likely to use them than services and contraceptives that are free.⁴

Setting up a fee payment system to recover some or all program costs requires several steps:

- Assessing the clients' willingness and means to pay
- Eliminating any administrative or legal barriers to collecting fees
- Determining how the collected fees will be used
- Determining what services and goods to charge for
- Establishing fee levels
- Setting up a system of administrative controls for all transactions, particularly those involving cash
- Collecting the fees from the clients

MIX OF CONTRACEPTIVE METHODS USED IN A PROGRAM

Ideally, each family planning program should offer a balanced selection of family planning methods, although sterilization and insertions of IUDs and Norplant implants are restricted to sites with appropriate facilities and trained staff. The methods offered by a program are influenced by the system in which they are distributed as well as by cultural or religious preferences and the reliability of the logistics system.

Although clinics and private physicians are generally able to offer all major contraceptive methods, not all service delivery approaches can be as comprehensive. Guidelines for offering various contraceptive methods under three delivery strategies are shown in Table 25:2.

Diaphragms and contraceptive creams and jellies are rarely available in most African clinics, even in urban areas. Clinic-based program staff should, therefore, concentrate on ensuring that pills, condoms, and spermicidal tablets are always available.

OBSTACLES TO SERVICE DELIVERY AND POSSIBLE SOLUTIONS

In many African countries, several barriers keep women from obtaining family planning services (in some areas, such services are just simply not available). These barriers, which can be both physical and cultural, often differ by area.

RURAL AREAS

In rural areas, the limited family planning services available are generally provided by the Ministry of Health or other government programs; a few missions, private family planning association clinics, or commercial retail sales programs may also exist. There are few government hospitals or clinics, and those that do exist sometimes lack water, electricity, equipment, or medicines. In some cases, government clinics are staffed by only one person and may close altogether if that person is ill, transferred to another post, or on maternity leave. Medicines are often limited to what has been supplied free to the government by international donors. To receive supplies, clinic staff may have to pick them up from a remote warehouse or store. When transportation is provided, the deliveries may be unreliable or sporadic. In rural areas, most potential clients are aware of these problems with health care services, and it is not surprising that they often seek services only in emergencies. When the need for family planning is outweighed by difficulties in obtaining services and supplies, unplanned pregnancies could result.

Table 25:2 Guidelines for use of contraceptive methods with alternative delivery strategies

Contraceptive method	Clinic-based	Community-based	Commercially distributed
Oral contraceptives: Low-dose combined pill and progestin-only pill. Can potentially be distributed by anyone with a checklist.	X	X	X
Intrauterine devices (IUDs): Must be inserted by a physician, nurse, or trained paramedic.	X		
Sterilization: Tubal ligation and vasectomy. Operation is mainly performed by physicians; can be performed by trained nurses and midwives. Must have the proper facilities.	X		
Injectable contraceptives: Depo-Provera and Noristerat. Injection can be given by physicians, nurses, or trained paramedics.	X	X	X
Implants: Long-acting hormonal implants (e.g., Norplant). Must be provided by someone, usually a physician, who has been trained in insertion and removal.	X		
Condoms, spermicides, foaming tablets: Nonmedical methods can be provided by anyone.	X	X	X
Creams, jellies, foams, diaphragms: Less popular non-medical methods. Diaphragm is usually fitted by a medical professional.	X	X	X
Instruction in fertility awareness methods: Timing of ovulation, abstinence. Trainer must be knowledgeable in the methods.	X		

Using a CBD program or a commercial retail sales program with widespread rural coverage could help alleviate several problems: lack of access to services, staffing shortages (particularly if the CBD program uses volunteers), and an emergency-only attitude toward health care services. A CBD program manager would still have to oversee the transportation and steady flow of supplies. CBD workers could be trained to provide some primary health care services.

URBAN AREAS

Lack of services and barriers to service are problems in urban areas as well, but family planning clients may find it easier to obtain services there because of the greater number of hospitals and clinics, which are better equipped and more fully staffed. Medical equipment and supplies are more likely to be available in urban areas because the transportation problems that affect rural areas are less severe. In addition, electricity and running water are available most of the time.

In cities, one important barrier to service is long waiting times, particularly early in the day. In addition, services are sometimes provided only on certain days (for example, maternal and child health [MCH] services on Monday, prenatal care on Tuesday, immunization on Wednesday). Such policies make it difficult for clients to get the services they want when they need them.

Because some clients may not be able to return on the day the service is scheduled, family planning program managers should try to integrate their services into existing facilities and offer them at the same time other services are offered. Doing so would be particularly important in MCH centers and for prenatal and postnatal programs, which are set up to serve women who are prime candidates for contraceptive services. Women accompanying their children to immunization clinics are also potential family planning clients; information on family planning can be made available to them while they wait. Long waiting times can often be reduced by studying how health care workers use their time and determining when the clients spend the most time waiting, then changing office hours or appointment systems.

Program managers might explore other ways to provide services to rural and urban areas, such as developing social marketing programs and household distribution programs or making referrals to clinics run by a local private family planning association.

OTHER OBSTACLES AND SOME SOLUTIONS

Sterilization

Sterilization is probably the family planning method most difficult to obtain in Africa. In rural areas sterilization is almost nonexistent, and in cities it is often unavailable because of the lack of necessary equipment and trained staff. Because increasing the availability of such services requires long-term funding for equipment and intensive staff training, the most practical short-term alternative is to provide clients with another contraceptive method.

Cultural Barriers

In many cultures, contraception is resisted by women, men, other family members, or the community at large. Still, people recognize the need to produce healthy children. Educating both clients and local leaders can help improve attitudes toward family planning and child spacing. Clinic staff should describe the health benefits that child spacing provides to both mothers and children. Staff can explain how the use of modern contraception serves the same purpose of child spacing that was traditionally achieved through practices such as abstinence and prolonged breastfeeding. Education can also diminish concerns about the side effects of specific methods. The provider should point out to new clients that complications from too many pregnancies, or even a single pregnancy, are far more dangerous than the side effects of any of the contraceptive methods.

Involving community leaders can help gain the confidence of the local population. The support of community leaders should be genuine and voluntary and derive from their belief that healthier children are advantageous to the community and put less of a strain on health

and educational services. Pressuring people to use contraception is ethically unacceptable and ineffective, even in the short term. Information and encouragement, however, are entirely appropriate.

Privacy

Lack of privacy in the provision of contraceptive and other medical services is a problem in some clinics. There are usually no short-term solutions to this problem, as it generally requires constructing or renting more office space. However, rearranging work-space areas or putting up curtains or screens often can improve the situation.

Some women want to use family planning but think their husbands will object. Methods that can be used without the knowledge of the husband are available; injectables are particularly appropriate in such situations. Sterilization (if available) is suitable when the woman decides she wants no more children, but she must be made aware that the procedure is not reversible.

Laws and Policies

In many African countries, particularly Francophone ones, laws dating to the early part of the 20th century officially prohibit the use of contraception. Program managers should work with higher ministry staff to gain support for repealing such laws, encouraging instead the voluntary use of contraception. However, even though such prohibitive laws exist, they are often not enforced, and in most countries, family planning services can be provided without interference. Many clinics also provide services to unmarried or teenage clients with little interference from authorities. To help overcome these barriers, the Ministry of Health can support providers by establishing client-oriented national service policies, norms, and protocols until the laws are changed.

Clinic Management

Some service delivery problems can be resolved by common-sense clinic management and by training. For example, a clinic management

analysis can indicate how staff spend their time and show ways to eliminate or change inefficient practices. Staff can be asked for suggestions on how the clinic could be better run or ways it could serve its clients better. Clients may also be asked to make suggestions.

Staff can be trained in improved program management skills or in new technical skills that allow them to provide additional services. However, training must be provided wisely. Pressing day-to-day problems are not solved by sending someone to school; indeed, the service problems may become worse if no one is available to replace the person being trained. Still, staff training must be a priority for clinic managers so that they can keep up with changes in medical procedures, diagnosis, and treatment. Fortunately, training in the use of most contraceptive methods is fairly simple, and it is possible for supervisors to conduct individual training sessions with their staff or to train groups on-site.

Obstacles to service delivery exist in every location. Family planning program managers and service providers need to consider what particular obstacles exist for their clients and potential clients, then develop solutions to improve access to family planning services. Obstacles can often be overcome by better management of the program itself and by providing better quality services. These topics are discussed in the next two chapters.

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